2019 NOVEL CORONAVIRUS RESOURCES

FOR LOCAL PUBLIC HEALTH PARTNERS

Last Updated 10/6/2020

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GUIDANCE

Travel related guidance for COVID-19
There is no longer a recommendation to self-isolate for 14 days after returning home from travel, as long as the traveler remains well and has not been identified as a close contact of COVID-19 positive person. This includes both domestic and international travel.

For additional information related to travel, please visit:
www.cdc.gov/coronavirus/2019-ncov/travelers/index.html

Isolation guidance for sick and/or COVID-19 positive members of the general public
Persons with symptoms of COVID-19 should self-isolate (this includes persons who test positive and persons who are not tested) until after these three things have happened:

- They have had no fever for at least 24 hours (that is one full day of no fever without the use of medicine that reduces fevers) **AND**
- Their other symptoms have improved (for example, when your cough or shortness of breath has improved) **AND**
- At least 10 days have passed since their symptoms first appeared.

Isolation recommendations for severe, advanced immunosuppressed persons
Persons with severe, advanced immunosuppression should stay home longer than 10 days, until:

- Two negative test results in a row, at least 24 hours apart **OR**
- 20 days post symptom onset or date of test

Persons with symptoms of COVID-19 who are tested and test PCR or antigen negative AND who ARE NOT a close contact of a person who tested positive for COVID-19, can go back to daily activities 24 hours after their fever and other symptoms resolve.

Persons with symptoms of COVID-19 who are tested and test PCR or antigen negative AND who ARE a close contact of a person who tested positive for COVID-19, should continue to self-quarantine until 14 days after their last exposure to the confirmed case.

Persons who test PCR or antigen positive for COVID-19 but do not experience symptoms should self-isolate until:

- At least 10 days have passed since the date of the first positive test AND
- They continue to have no symptoms (no cough or shortness of breath) since the test.

Re-exposure recommendations for persons previously infected with COVID-19
If previously diagnosed with COVID-19, but have since recovered and remain asymptomatic:

- Retesting is not recommended within three months after the date of symptom onset (or date of test if asymptomatic persons) for the initial COVID-19 infection
- Quarantine is not recommended in the event of close contact with an infected person during the three month time period, as long as the previously infected person remains asymptomatic

In persons who develop new symptoms consistent with COVID-19 during the 3 months after the date of initial symptom onset (if an alternative etiology cannot be identified by a provider), re-testing should be considered.

- The symptomatic person should be isolated again until the 10/1 rule is met, unless a healthcare provider provides an alternate diagnosis or is tested for COVID-19 and receives a negative COVID-19 result.
- No contact tracing is necessary.

If a person previously diagnosed with COVID-19 becomes ill with symptoms consistent with COVID-19 or tests positive ***more*** than 3 months following the date of symptom onset (or date of test if asymptomatic persons), they should be treated as any other newly positive individual, not taking their previous illness into account for the purposes of public health action.

NOTE: Persons who test positive for COVID-19 on serologic testing should not be excluded, unless they also test positive for COVID-19 on PCR or antigen testing or are sick with COVID-19 symptoms and have not yet met the isolation release guidance described above.

CDC Guidance for "What to do if you are sick":
www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/steps-when-sick.html

Guidance for asymptomatic healthcare personnel exposed to individuals testing PCR or antigen positive for COVID-19

This guidance applies to HealthCare Personnel (HCP)* with potential exposure in a healthcare setting to patients, visitors, or other HCP with confirmed COVID-19. Exposures can also be from a person under investigation (PUI) who is awaiting testing. Work restrictions described in this guidance might be applied to HCP exposed to a PUI if test results for the PUI are not expected to return within 48 to 72 hours. Therefore, a record of HCP exposed to PUIs should be maintained. If test results will be delayed more than 72 hours or the patient is positive for COVID-19, then the work restrictions described in this document should be applied.

Exposure	**Personal Protective Equipment Used**	**Work Restrictions**
HCP who had prolonged[1] close contact[2] with a patient, visitor, or HCP with confirmed COVID-19[3]	- HCP not wearing a respirator or facemask[4] - HCP not wearing eye protection if the person with COVID-19 was not wearing a cloth face covering or facemask - HCP not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while performing an aerosol-generating procedure[1]	- Exclude from work for 14 days after last exposure[5] -Advise HCP to monitor themselves for fever or symptoms consistent with COVID-19[6] - Any HCP who develop fever or symptoms consistent with COVID-19[6] should immediately contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.
HCP other than those with exposure risk described above	N/A	-No work restrictions -Follow all recommended infection prevention and control practices, including wearing a facemask for

		source control while at work, monitoring themselves for fever or symptoms consistent with COVID-196 and not reporting to work when ill, and undergoing active screening for fever or symptoms consistent with COVID-196 at the beginning of their shift. -Any HCP who develop fever or symptoms consistent with COVID-196 should immediately self-isolate and contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing**.**

HCP with international travel or community exposures should inform their occupational health program for guidance on need for work restrictions.

1. Consider an exposure of 15 minutes or more (within <6 feet) as prolonged. Any duration should be considered prolonged if the exposure occurred during performance of an aerosol generating procedure.
2. Data are limited for the definition of close contact. For this guidance it is defined as: a) being within 6 feet of a person with confirmed COVID-19 or b) having unprotected direct contact with infectious secretions or excretions of the person with confirmed COVID-19.
3. Determining the time period when the patient, visitor, or HCP with confirmed COVID-19 could have been infectious:
    a. For individuals with confirmed COVID-19 who developed symptoms, consider the exposure window to be 2 days before symptom onset through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions
    b. For individuals with confirmed COVID-19 who never developed symptoms, determining the infectious period can be challenging.
        i. In these situations, collecting information about when the asymptomatic individual with COVID-19 may have been exposed could help inform the period when they were infectious. In general, individuals with COVID-19 should be considered potentially infectious beginning 2 days after their exposure until they meet criteria for discontinuing Transmission-Based Precautions.
        ii. If the date of exposure cannot be determined, although the infectious period could be longer, it is reasonable to use a starting point of 2 days prior to the positive test through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions for contact tracing.
4. While respirators confer a higher level of protection than facemasks and are recommended when caring for patients with COVID-19, facemasks still confer some level of protection to HCP, which was factored into this risk assessment. Cloth face coverings are not considered PPE because their capability to protect HCP is unknown.
5. If staffing shortages occur, it might not be possible to exclude exposed HCP from work. For additional information and considerations refer to Strategies to Mitigating HCP Staffing Shortages.
6. Fever is either measured temperature ≥100.4°F or subjective fever. Note that fever may be intermittent or may not be present in some patients, such as those who are elderly,

immunosuppressed, or taking certain medications (e.g., NSAIDs). Clinical judgement should be used to guide testing of patients in such situations. Occupational health programs should have a low threshold for evaluating symptoms and testing HCP

* Healthcare Personnel (HCP): HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, volunteer personnel). For this guidance, HCP does not include clinical laboratory personnel.

For additional information visit:
www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

Return to work guidance for sick and/or COVID-19 positive healthcare personnel
Symptomatic HealthCare Personnel (HCP)* with suspected or confirmed COVID-19 should be excluded from work until:

- At least 24 hours have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**,
- At least 10 days have passed *since symptoms first appeared*

Healthcare personnel with laboratory-confirmed COVID-19 who have not had any symptoms should be excluded from work until:

- 10 days have passed since the date of their first positive COVID-19 diagnostic test assuming they have not subsequently developed symptoms since their positive test.

After returning to work, the healthcare provider should:

- Wear a facemask for source control at all times while in the healthcare facility until all symptoms are completely resolved or at baseline.
    - A facemask instead of a cloth face covering should be used by these HCP for source control during this time period while in the facility. After this time period, these HCP should revert to their facility policy regarding universal source control during the pandemic.
    - A facemask for source control does not replace the need to wear an N95 or higher-level respirator (or other recommended PPE) when indicated, including when caring for patients with suspected or confirmed COVID-19.
    - Of note, N95 or other respirators with an exhaust valve might not provide source control.
- Self-monitor for symptoms, and seek re-evaluation from occupational health if respiratory symptoms recur or worsen.

CDC "Return to Work Criteria for Healthcare Personnel with Confirmed or Suspected COVID-19"
www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html

Screening guidance
According to CDC, COVID-19 symptoms may appear 2-14 days after exposure to the virus. People with these symptoms or combinations of symptoms may have COVID-19:

- Cough
- Shortness of breath or difficulty breathing
- New loss of taste or smell

Or at least two of these symptoms:

- Fever
- Headache
- Muscle or body aches
- Fatigue
- Sore throat
- Runny Nose
- Congestion
- Nausea
- Vomiting
- Diarrhea

IDPH has not changed business screening guidance due to the complexity of the screening process that would need to occur to account for the broader list of symptoms. Businesses can create their own algorithm for screening based upon the expanded CDC information or they can continue to use the current IDPH screening algorithm available at:
https://idph.iowa.gov/Portals/1/userfiles/7/bscreening%20algorithm%2003222020.pdf

Guidance for Critical Infrastructure Workers exposed to COVID
Critical infrastructure workers, including personnel in 16 different sectors of work including:

- Federal, state, & local law enforcement
- 911 call center employees
- Fusion Center employees
- Hazardous material responders from government and the private sector
- Janitorial staff and other custodial staff
- Workers – including contracted vendors – in food and agriculture, critical manufacturing, informational technology, transportation, energy and government facilities

Critical infrastructure workers may continue work following potential exposure to COVID-19, provided they remain asymptomatic and additional precautions are implemented to protect them and the community. A potential exposure means being a household contact or having close contact within 6 feet of an individual with confirmed or suspected COVID-19. The timeframe for having contact with an individual includes the period of time of 48 hours before the individual became symptomatic.

Critical Infrastructure workers who have had an exposure but remain asymptomatic should adhere to the following practices prior to and during their work shift:

Pre-Screen: Employers should measure the employee's temperature and assess symptoms prior to starting work. Ideally, temperature checks should happen before the individual enters the facility.
Regular Monitoring: As long as the employee does not have a temperature or symptoms, they should self-monitor under the supervision of their employer's occupational health program. Wear a Mask: The employee should wear a face mask at all times while in the workplace for 14 days after last exposure. Employers can issue facemasks or can approve employees' supplied cloth face coverings in the event of shortages.
Social Distance: The employee should maintain 6 feet and practice social distancing as work duties permit in the workplace.
Disinfect and Clean Work Spaces: Clean and disinfect all areas such as offices, bathrooms, common areas, shared electronic equipment routinely.

For additional Guidance visit:
www.cdc.gov/coronavirus/2019-ncov/downloads/critical-workers-implementing-safety-practices.pdf

COVID-19 Testing Framework for Iowa (updated 08.06.2020)
Healthcare providers can test patients as they deem appropriate for COVID-19 infection at reference or hospital laboratories. If healthcare providers choose to test a patient through a reference or hospital laboratory, there is no need to call IDPH for approval. The specimens should be sent directly to the reference or hospital laboratory in accordance with the laboratory's guidance. These laboratories typically charge patients for this testing; public health has no funding to cover the costs of these tests.

Viral Test for COVID-19
The State Hygienic Laboratory will continue to perform COVID-19 PCR testing in accordance with one of the following criteria (these criteria may broaden as the pandemic expands and additional testing resources become available).

- Hospitalized patient (of any age) with fever or respiratory illness for diagnosis or any hospitalized patient prior to discharge to a long term care facility or other nursing care facility
- Older adult (> 60 years of age) with fever or respiratory symptoms (e.g., cough, difficulty breathing) and chronic medical conditions (e.g., diabetes, heart disease, immunosuppressive medications, chronic lung disease, or chronic kidney disease)
- Person of any age with fever or respiratory illness who lives in a congregate setting (i.e., long term care facilities, dormitories, residential facilities, correctional facilities, treatment facilities)
- Healthcare worker, essential services personnel, first responder, or critical infrastructure worker with fever or respiratory illness (e.g., healthcare worker, fire, EMS, law enforcement, residential facility staff, food supply, and water plant operators)
- Children receiving care in and staff working in childcare homes and childcare centers with fever or respiratory symptoms (e.g., cough, difficulty breathing) without alternative diagnosis
- Preschool / K12 students and staff with fever or respiratory symptoms (e.g., cough, difficulty breathing) without alternative diagnosis
- University / college students and staff with fever or respiratory symptoms (e.g., cough, difficulty breathing) without alternative diagnosis
- Symptomatic and asymptomatic close contacts (defined as spending more than 15 minutes within 6 feet) of persons who test positive for COVID-19 infection using PCR viral testing (close contact testing should not occur until at least 48 hours after the earliest exposure to COVID-19 positive persons)

If patients meet the testing criteria, please submit the specimen to the State Hygienic Laboratory in accordance with the diagnostic PCR testing guidance available at, http://shl.uiowa.edu/dcd/covid19.xml.The cost of this testing is assigned to the public health system.
Please ensure you are using appropriate infection control guidance when collecting specimens, which includes at a minimum contact and droplet precautions with eye protection.

Antibody Testing for COVID-19
The State Hygienic Laboratory will perform COVID-19 serology (antibody) testing in accordance with one of the following criteria (these criteria may broaden as the pandemic expands and additional testing resources become available).

- A patient suspected or confirmed to have COVID-19 who is greater than 7 days post symptom onset, or a patient exposed to a known case of COVID-19 more than 7 days in the past
- Identification of persons with an antibody response to serve as convalescent plasma donors
- Healthcare worker, essential services personnel, first responder or critical infrastructure worker (e.g., healthcare worker, fire, EMS, law enforcement, food service worker and residential facility staff) for whom knowledge of antibody production is needed

If patients meet the testing criteria, please submit the specimen to the State Hygienic Laboratory in accordance with the serologic antibody testing guidance, available at http://shl.uiowa.edu/dcd/covid19.xml.The cost of this testing is assigned to the public health system.

CASE INVESTIGATION AND CONTACT TRACING PROCEDURES

Test types and the Iowa Disease Surveillance System
There is an increasing number of test types being on-boarded in Iowa and at reference laboratories across the nation. There are two main categories of testing, PCR/antigen testing and serology testing. IDPH has decided to separate these types of testing into two different diseases on the Iowa Disease Surveillance System. This decision to separate into two distinct diseases was made in an effort to prevent confusion and streamline the reporting process.

A positive PCR or antigen test indicates a current COVID-19 infection.

- PCR and antigen results are categorized in Iowa Disease Surveillance System under the disease name “2019 Novel Coronavirus”

A positive serology test indicates a past or recent COVID-19 infection.

- Serology results are categorized in the Iowa Disease Surveillance System under the disease name “Serology COVID-19”

Additional information about PCR, antigen, and serology testing is available at:
www.cdc.gov/coronavirus/2019-ncov/php/testing.html
www.cdc.gov/coronavirus/2019-ncov/lab/serology-testing.html
www.cdc.gov/coronavirus/2019-ncov/covid-data/serology-surveillance/index.html

PCR and antigen case investigation and contact tracing procedures
Local public health partners that have decided to complete their own case investigations and contact tracing should run an IDSS “local outstanding follow-up report” to identify positive results that need investigated.

To run a "local outstanding follow-up report" log into the IDSS system and click on the printer icon at the top left side of the dashboard. Select "local outstanding follow-up report" from the list and the report will generate, listing the open cases in IDSS for your jurisdiction.

Local public health departments should perform case investigations in accordance with normal investigation procedures. In addition, IDPH is asking local public health to identify all persons that the case had contact with during their infectious period.

Close contact is defined as:

- ***living in the same household as an infectious person (irrespective of whether face coverings are used in the household)***

- ***being less than 6 feet away from an infectious person for more than 15 consecutive minutes***
  NOTE: In non-healthcare and non-household settings, close contacts are persons less than 6 feet away from an infectious person for more than 15 consecutive minutes AND the case, the close contact, or both were not wearing a face covering during the interaction
  - ***Acceptable face coverings are described in CDC guidance available at:*** www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/about-face-coverings.html

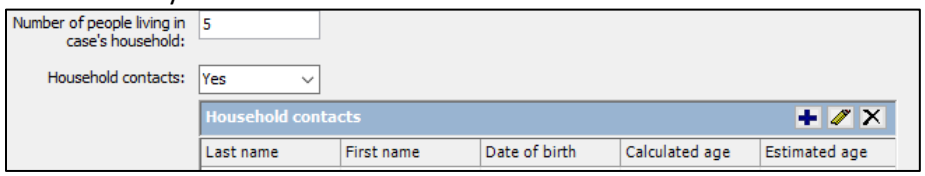
The infectious period for asymptomatic cases is defined as **48 hours before through 10 days after** the first date the patient tested positive for COVID-19 infection.

The infectious period for symptomatic cases is defined as **48 hours before illness started until the patient is fever free for at least 24 hours AND other symptoms have improved AND at least 10 days have passed since the first symptom began**.

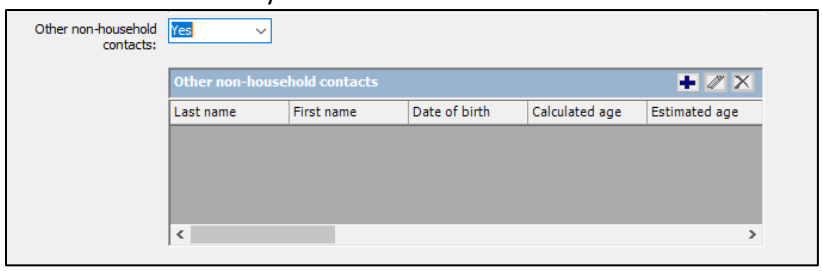
Local public health is asked to:

- identify all persons meeting the close contact definition
  - NOTE: in non-healthcare and non-household settings close contacts are persons less than 6 feet away from an infectious person for more than 15 consecutive minutes AND the case, the close contact, or both were not wearing a face covering during the interaction
- call each close contact, ask whether they have been ill, and instruct them that they have been exposed to COVID-19 and provide guidance accordingly
  - asymptomatic close contacts should quarantine for 14 days following their last exposure
- advise all close contacts (asymptomatic and symptomatic) that it is recommended (not required) that they be tested for COVID-19 infection (testing should not occur before 48 hours after their earliest exposure to the COVID-19 infected case)
- all close contacts should be recorded in the "contacts" section in the Iowa Disease Surveillance System (as shown below)
- ill close contacts should be entered as epi-linked cases in the Iowa Disease Surveillance System

Household contacts should be entered in the “Household Contacts” section of the Iowa Disease Surveillance System:



All other close contacts should be entered in the “Other non-household contacts” section of the Iowa Disease Surveillance System:



Serology Case Investigations

As of September 4, 2020, IDPH is no longer asking local public health partners to conduct investigations for persons with positive serology results. As serology positive results indicate past infection (and the infectious period cannot be determined), no contact tracing is conducted for these cases.

Long Term Care Illness and Outbreak Investigation

When one or more resident(s) of long term care facilities test positive for COVID-19, IDPH and the appropriate local public health department will hold a conference call to discuss the following:

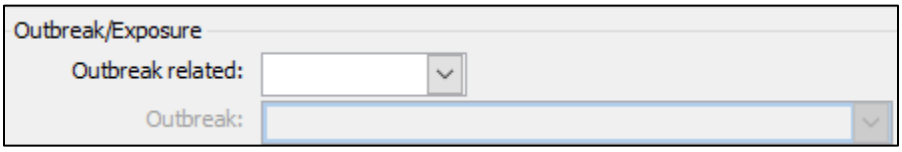
- Review recommendations available at: https://idph.iowa.gov/Portals/1/userfiles/7/LTC%20Outbreak%20Document%20.pdf
  - Screen all employees for fever and cough/breathing problems at start and end of each shift. Ill staff should be sent home immediately.
  - Isolate all symptomatic residents in single rooms.
  - Cohort staff so that dedicated staff are working with ill residents and not with healthy residents.
  - Employees should use face masks and eye protection ALL times for ALL resident care.
  - Consider gown and glove use at all times for all resident care (if available).
  - No visitors should be allowed in the facility (unless end of life situation per CMS guidance).
  - Screen all patients for fever and cough/breathing problems daily.
  - Coordinate with local public health department, EMS and hospitals to plan for higher care needs (when and where to transfer and how to communicate COVID-19 risk to transport team and accepting facility).
  - Understand that the residents’ illness may worsen on day 7 to 8 of symptoms.
  - Work with local public health to ensure test kits are readily available for any additional residents that become symptomatic.
  - Identify other healthcare facilities where staff work. Staff should not work in other facilities if possible, or should use a face mask with eye protection for all patient care in any health care setting.
  - Establish a plan for communication with staff, residents and families, public health, and the public.

- Discuss PPE needs
- Competency in hand hygiene and PPE donning and doffing.
- Review environmental services cleaning products and procedures
- Discuss testing supply needs
- Discuss current staffing needs and staffing contingency plans (i.e., relationship with parent company or staffing agency)
- Discuss adherence to routine PPE use recommendations and familiarity with donning and doffing procedures

From that call forward, local public health is asked to contact the long term care facility daily to:

- Review newly identified symptomatic or confirmed residents/staff
- Discuss epidemiologic links of new cases to previous cases (i.e., are they on the same hallway/neighborhood)
- Discuss adherence to routine PPE use recommendations and familiarity with donning and doffing procedures
- Review environmental services cleaning procedures
- Discuss how the staff and patient cohorting plan may need to be altered based on the positive case (do we need to start cohort staff on another hallway/neighborhood/wing)
- Discuss whether wider hallway/neighborhood/wing testing is indicated
- Discuss patients potential for worsening and transfer plan if higher level of care is needed
- Discuss current PPE needs
- Discuss current testing supply needs
- Discuss current staffing needs

IDPH staff will create an "Outbreak Name" corresponding to each long term care facility with at least one reported case in a resident. The "Outbreak" field within the Iowa Disease Surveillance System appears in the "Event continued" tab. Local public health departments should identify all LTC staff and residents tested for COVID-19 (both positive and negative results) as being associated with the specific long term care facility where they work or reside in the Iowa Disease Surveillance System (by selecting the LTC facility name from the outbreak list). If a staff member lives in another county (and LPH does not have access to the case), please notify Amanda Casson at IDPH (amanda.casson@idph.iowa.gov) and she will apply the outbreak field for that staff member in the Iowa Disease Surveillance System.



In addition, IDPH is asking that all local public health departments consider completing case investigations on long-term care residents if possible since they will be contacting those facilities daily. Because contact tracing will need to occur with long term care staff and staff may live in other counties, IDPH would propose handling the staff investigations like all other non-resident cases occurring in the county.

Starting on Monday, May 11, 2020, IDPH will no longer request that local public health partners/long term care facilities update line lists. Local public health partners may choose to continue using the line list at their discretion; however, it does not need to be sent to IDPH.

NOTE: IDPH is assigning outbreaks to cases in IDSS that are listed in the current tracking spreadsheets, but local public health is asked to transition to assigning cases to outbreaks in IDSS starting on Monday, May 11, 2020. This request is being made of all LPH partners, including the LPH departments that have requested that the state investigate cases within their jurisdiction.

Long term care facilities with at least three residents that test positive for COVID-19 will be listed on the outbreak dashboard on the COVID.iowa.gov webpage. The data for the dashboard will be exported directly from the Iowa Disease Surveillance System. Facilities will remain listed on the dashboard until 28 days (2 incubations periods) after their most recent new case became ill/was identified.

Long Term Care Facilities Concerned About False Positive Antigen Testing Results as Part of CMS Required Repeat Testing Protocols

If a Long Term Care (LTC) facility suspects false positive antigen results in ASYMPTOMATIC staff and ASYMPTOMATIC residents AND the long term care facility is NOT currently experiencing an outbreak (defined as at least three positive residents), the following procedures can be considered:

The ASYMPTOMATIC staff or ASYMPTOMATIC resident can be re-tested twice using confirmatory PCR testing,

- The first PCR specimen must be collected within 48 hours of when the positive antigen specimen was collected.
- The second PCR specimen must be collected at least 24 hours after the first PCR specimen was collected.
- If BOTH PCR specimens test NEGATIVE, the original antigen result should be considered a false positive result.

When PCR results are pending, the ASYMPTOMATIC staff member should be isolated and their close contacts should be in quarantine. If the ASYMPTOMATIC staff member is determined to have a false positive antigen result (in accordance with the guidance above) the ASYMPTOMATIC staff member can stop isolation and return to work. Close contacts in quarantine should be released, as well.

When PCR results are pending in ASYMPTOMATIC residents, the long term care facility should transfer the ASYMPTOMATIC resident to a single room if there is a roommate, implement use of Transmission-Based Precautions, and dedicate staff. The long term care facility should not transfer the ASYMPTOMATIC resident to a COVID-19 unit or place them in another shared room with new roommates. Close contacts should be identified and quarantined. If the ASYMPTOMATIC resident is determined to have a false positive antigen result (in accordance with the guidance above) COVID-19 14 precautions should be discontinued in the long term care facility. Close contacts in quarantine should be released, as well.

Additional Information:

This confirmatory testing strategy should only be applied in a long term care setting. At this time, this strategy DOES not apply to antigen testing occurring in the community.

Confirmatory PCR testing for ASYMPTOMATIC staff and ASYMPTOMATIC residents previously testing positive on antigen tests, can be performed at the State Hygienic Laboratory (SHL) at the discretion of the long term care facility.

Long term care facilities should be advised to report false positive antigen results through FDA's medwatch www.fda.gov/safety/medwatch-fda-safety-information-and-adverse-eventreporting-program

This guidance is subject to change as federal guidance is released and clarified, and as additional Iowa-specific data is collected.

State assistance with investigations and contact tracing
State resources are available to assist local public health departments in completing PCR/Antigen investigations. Local public health departments can defer investigations to the state by contacting their assigned IDPH Field Epidemiologist.

Local public health departments can access both test and case investigation information for residents in their jurisdiction at any time by logging into the Iowa Disease Surveillance System.

School Follow-up Process
When a staff member or student at a school is identified as having tested positive for COVID-19 via PCR or antigen test, local public health departments should generally take the following actions:

- If the result is not in IDSS, verify via parent/health care provider that the individual indeed tested positive for COVID-19 via PCR or antigen test.
- Determine the positive individual's infectious period, based off date of symptom onset or collection date, as appropriate. Determine when the staff member or student wore a face covering during their infectious period.
- If the school is not already aware, notify the school of the positive staff member or student.
- Work with the school to identify close contacts among staff and students at the school – those within 6 feet of the infectious individual for 15 consecutive minutes. If the case AND the close contact were wearing a face covering, quarantine is not recommended.
- Notify staff and parents of children who were identified as close contacts. Recommend close contacts stay home, as appropriate.

NOTE: School staff identified as being a close contact may be considered critical personnel and allowed to return to work during the 14 days following exposure if there are staffing shortages, as long as they remain asymptomatic. During this time, they should take their temperature and screen for symptoms at the start and end of each day, and wear a mask at work. If symptoms develop, they must isolate immediately.

Support for Businesses
The testing framework above allows ill critical infrastructure workers presenting to healthcare with COVID-19 symptoms to be tested through the State Hygienic Laboratory.

For additional COVID-19 guidance and consultation for Iowa businesses, please contact covid19business@iowa.gov.